THE PRIVATE MEDICAL SECTOR IN INDIA

[Monograph Prepared from paper Commissioned
for the updated (1994) volume of
'Health Status of the Indian People']

DR. ANANT PHADKE

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

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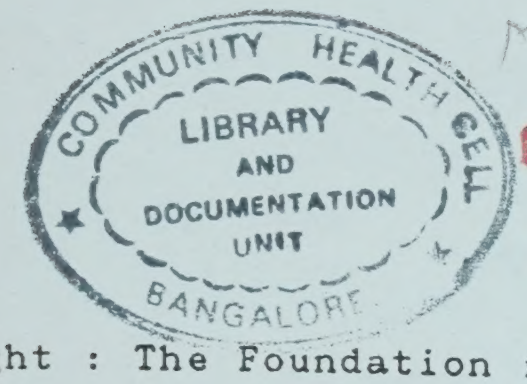
Produced by : The Foundation for Research in Community Health
84 - A, R.G. Thadani Marg, Worli Sea Face
Bombay 400 018, Maharashtra, INDIA



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FOREWORD

The private sector in health is now responsible for three quarters of the medical manpower as well as the total expenditure of the country on health which now consumes 6% of the Gross Domestic Product. It varies from the high profile 5-Star hospitals, to a much greater number of nursing homes and an even larger number of private practitioners of various qualifications from super specialists to the unqualified Registered Medical Practitioners. While the public health services bear almost all the preventive and promotive load of health-care, they also have to provide basic and even sophisticated curative services to those who cannot afford to pay for such care. This sector also trains, at public cost, 70% of the medical and paramedical personnel who eventually serve the private sector.

While information is available about the services and cost of the public sector, there is virtually no published information on the far larger private sector which provides curative services to those who can pay for their services. This sector derives substantial benefits from the public exchequer, like free training of their personnel as well as tax and import duty exemptions. Yet, in the search for ever increasing profit in an area where consumer resistance is at its lowest, the private sector has not only relegated the non profit preventive and promotive services to the public sector, but has converted illness-care into an increasingly sophisticated, expensive, Western style business, with the support of the pharmaceutical and medical instrumentation industry. The over production of doctors and drugs, that too of the wrong types, has built in a type of malpractice to which the middle class has responded by invoking the Consumer Protection Act.

This is one of the very few reports available on the private health sector in India. It not only analyses the development of this sector and its present status but also indicates how it should be regulated to form a useful part of the overall health care system of the country. We hope, this will help in starting a debate between the medical profession and the public and also help to evolve a workable system, acceptable to both.

That much of the information is based on press clippings and other sources is because of the paucity of researched data. It is hoped this would stimulate researchers to elicit necessary data for better understanding of this sector, however difficult this may be.

Dr. N.H. Antia
Chairman and Director

April, 1994

THE PRIVATE MEDICAL SECTOR IN INDIA

(Abstract)

The private medical sector in India accounts for 61% to 86% of the total medical expenditure, 73% of allopathic doctors, a much larger proportion of non-allopathic doctors, 56% of hospitals and 30% of hospital-beds. In spite of this dominant share that the private sector occupies, there are hardly any studies which have looked into its role and functioning. (The role of the drug-industry is an exception).

This lacuna is especially glaring in the context of the recent trend towards further privatization of medical care. In this paper, we have tried to study different aspects of the private medical sector such as general practitioners, consultants, hospitals, laboratories, medical colleges, etc., with a view to analyse how appropriate is this private sector in fulfilling the health care needs of the Indian people and to find out what reforms are needed to make it fulfill its role.

Though the private medical sector in India is more accessible to and popular with those who can easily afford to pay for it, it suffers from a number of features which are inimical to the interests of a rational, affordable, socially desirable form of medical care system. These are - socially inappropriate, costly, sub-standard medical education; lack of adequate, proper Continuing Medical Education; gross urban-rural disparity in the availability of qualified medical practitioners; irrational drug use; unnecessary and unethical medical interventions; sub-standard quality of medical care; lack of rationalization of professional charges; paucity of record keeping; lack of preventive measures and health-education; unqualified, poorly paid paramedic staff; lack of professional self-regulation. Many of these features are also present in the public health care system but they are much more pronounced in the private medical sector. Each of these problems is briefly examined below :-

I> Inappropriate Medical Education

Medical education in India is elitist, biased towards curative care, hospital-oriented, wasteful and socially inappropriate. Private medical colleges, barring exceptions, are no solution to these problems. Yet their role has been increasing. The number of allopathic medical colleges in India has increased from 28 to 125 from 1950 to 1987. During this period, the proportion of private medical colleges has increased from 3.5% to 17%. Twelve out of eighteen new medical colleges opened during 1974-1986 were in the private sector. By 1986, the proportion of private medical colleges in Ayurvedic, Homeopathic, Unani medical colleges was 67%, 65%, 75%, respectively. This proliferation of private medical colleges is inimical to the interest of rational, affordable medical care for three reasons :

1) There is no need to open new medical colleges anymore. Looking at the current output from the existing medical colleges, by the year 2000 A.D. there will be one MBBS doctor per 2000 population and one doctor of whatever degree, per 1000 population. This ratio is satisfactory for a developing country like India. Secondly, experience shows that merely producing more doctors is not the solution for paucity of doctors in rural areas; MBBS and post-graduate doctors tend to flock to the cities. Use of well-trained, well-supported paramedics is the more appropriate solution to the paucity of doctors in rural areas. Doctors from private medical colleges increase the urban concentration of doctors since it is only in cities that they can earn back their substantial investment in medical education.

2> Private colleges charge from 3-5 lakh rupees per student. As of 1993-94, these fees are now standardized by the state - Rs. 1.72 lakh per year for "paying" students! Any doctor who has spent so much on education is bound to recover it from his patients. This can only be done by indulging in excessive billing and unnecessary medical interventions, thus further lowering the ethical standards in medical practice.

3> Most of the private medical colleges are sub-standard and are not recognised by the Indian Medical Council.

Private medical colleges thus worsen the situation in the field of medical education and hence need to be banned.

II> Lack of Continuing Medical Education (CME)

Unlike in some Western countries, a doctor's registration in India is renewed without undergoing any CME. There are voluntary efforts at CME. For example, many branches of the Indian Medical Association conduct CME-programmes for their members and IMA runs a monthly Journal of Indian Medical Association (JIMA) for its members. But out of 3.5 lakh MBBS doctors in India, less than 25% are members of IMA, and about 10-25% attend its CME programmes. For the eight lakh non-allopathic doctors (Homeopaths, Ayurveds, etc.) there is hardly any proper CME. Most of them prescribe allopathic medicines ("cross- prescriptions") and depend more or less solely on the Medical Representatives of drug companies for their knowledge of allopathic drugs. As a result, the half-truths and untruths propagated by the drug companies are uncritically accepted by the medical profession.

A National Medical Education Board has to be set-up, which would, through its state branches, deliver compulsory CME to doctors. Renewal of registration of doctors should be subject to satisfactory completion of CME. Cross-prescriptions should be banned or should be allowed strictly in accordance with proper training in the other pathy.

III> Irrational Drug Use

Most of the drugs marketed in India are in the form of drug-combinations and most of these drug-combinations are irrational and some are even hazardous. Yet they are widely prescribed in India, especially in the private sector. In the Public Health facilities, the health authorities draw up a list of rational, essential drugs and the District Health Officers are to buy medicines in accordance with this list. The centralized purchases of drugs in the public sector are therefore mostly of rational drugs. But in the private sector, all kinds of irrational drugs are prescribed. This is confirmed by the preliminary results of a study of prescription practices in a typical district in Maharashtra. It was found that prevalence of use of irrational or hazardous or unnecessary drug or injection is far more common in the private clinics than in the Primary Health Centres. This can be seen from the Table in the following page.

Unnecessary use of injections and intravenous infusions is the most glaring and the most common unnecessary medical intervention. This, again, is much more common in private practice since there is

a strong financial incentive in unnecessarily using this costly mode of medical interventions. To remedy this situation, only rational drugs and rational drug-combinations should be allowed; all others should be banned. Along with continuing education of doctors, there has to be extensive and continuous health education of lay-people so that patients do not ask for injections or "powerful medicines" due to their misplaced faith in them. A practice of paying "examination fee" to a general practitioner has to be instituted. Lack of this practice is partly responsible for unnecessary use of injections.

IV> Unnecessary and Unethical Medical Interventions

Unnecessary surgeries and laboratory tests are on the rise. This is because of increasing urban concentration, increasing commercialization and the rise of the corporate sector in Medical Care. To the list of unnecessary removal of appendix, tonsils, uterus, etc., are added new high-tech procedures like heart operations. According to a senior heart surgeon in Bombay, 40% of coronary angioplasties and 20% of coronary bypass surgeries done in Bombay are unnecessary! It is quite common for a CAT-Scan centre to offer commissions to doctors for sending their patients for this costly investigation.

The sale of kidneys for transplants; misuse of prenatal diagnostic tests for detection of the sex of the foetus and the subsequent elimination of female foetuses; buying of blood from professional blood donors and the consequent risk of spread of AIDS, Hepatitis - these murky deeds are a special feature of the private medical sector. These nefarious practices must be stopped with a heavy hand. Standard treatment guidelines should be worked out by medical bodies so that unnecessary medical interventions can be easily singled out.

V> Sub-standard Medical Care

Many private practitioners buy medicines from many small companies who do not mind selling sub-standard, cheap drugs to practitioners. Many private nursing homes neither have adequate floor space, ventilation, cleanliness, or adequate water supply, nor well-trained staff. This was recorded by a Committee of the West Bengal Legislative Assembly in 1985. The Nursing Homes Act is merely on paper, wherever it exists (as in case of some of the metropolitan cities). Minimum standards for private hospitals must be laid down and strictly enforced.

VI> Arbitrary Professional Charges

There is no principled basis for the level of fees to be charged by the doctor. The rule seems to be - charge as much as the patient can bear. A pediatrician from a small town may charge Rs. 20/- as consultation, as compared to Rs. 100/- in a city like Bombay. Similarly, charges for Caesarean delivery may vary from Rs. 500/- in a small town to Rs. 5000/- in Bombay. Cost of living, knowledge and experience of the doctor, type of surgery - all these should be properly considered to standardize charges. An individual patient is helpless to influence doctors' fees, especially in a life-threatening situation. This underscores the importance of standardizing doctors' charges.

VII> Paucity of Record-keeping

General practitioners and small hospitals keep (if at all) very cursory and inadequate records of their medical findings, not to mention statistics and proper accounts. The doctor's medical findings are not available to the patients as a matter of right. There is, therefore, no scope for any medical audit to evaluate the performance of the doctor.

There must be minimum mandatory record-keeping by doctors and it should be available to the patient as a matter of right, when he/she asks for it.

VIII> Lack of Preventive Measures and Health Education

Private practice, by its very nature, is confined to individualized relation between a patient and a doctor. So long as the patient is relieved of his/her suffering, the job of the private practitioner is considered to be over. But the disease process originates at a social level, e.g. defective water supply to a community or promotion of tobacco. Doctors should therefore participate in the collective action to control diseases because they have the knowledge about these. But private doctors, by and large, do not participate in the National Health Programmes like Tuberculosis, Malaria, Leprosy Control Programmes, etc.

Similarly curative, preventive, promotive health practices and their rationale need to be propagated through health educational activities. But private practice, by its very nature, tends to neglect these health educational activities, especially on a social scale. This also holds true for the medical profession as a body, although some exceptional doctors, through their individual

efforts, do undertake health education activities by writing articles for lay people, giving popular talks, etc. The magazines published by IMA "Your Health" and "Aapka Swasthya" (in Hindi) are not widely circulated; in fact they are hardly known. Notable exceptions are The Diabetic Association of India which, in some places, has been active for years together in educating lay people about diabetes.

The content of health education is also affected by the needs of private practice. On the one hand, aspects of science of medicine are explained to the people. On the other hand, the overall impact of such health education is to narrow down the concept of disease-process to merely its biological aspects while ignoring the broader social causes such as environmental degradation or an unhealthy life-style. Secondly, such health education mystifies medicine and exaggerates the importance of doctors. In short, consciously or unconsciously, such health education serves to expand the market of medical care.

IX> Unqualified, Poorly Paid Staff

Most assistants employed in the private sector, except in big hospitals, are under-qualified. Given their low educational qualifications and the very superficial training given by the doctors, most assistants cannot cope with the responsibilities they have to handle. The quality of care thus suffers. Due to long hours of work (in many small hospitals, the shift stretches to 12 hours) and poor wages, poor avenues of progress, the staff is dissatisfied and this, in turn, adversely affects the quality of their work.

There is a need for proper education and continuing education of paramedics in the private sector; also some incentive in the form of a share in the prosperity of the hospital or clinic.

X> Lack of Professional Self-regulation

Medicine is not mere business. It is an honorable profession with its own code of ethics and a statutory body (the Medical Council of India) to uphold the dignity of the medical profession. But in practice, the MCI is quite inactive and ineffective in curbing irrational practices and malpractices. Neither MCI nor the voluntary body - Indian Medical Association are regulating the quality of medical care or curbing unethical practices in the medical field. Everything is left to the "law of the market". There has to be some effective mechanism of ensuring professional standards and ethics in the medical profession.

XI> Conclusion

The above very brief survey of the private medical sector in India forces us to conclude that the private medical sector suffers from many serious problems and hence needs drastic reforms. The nature of these reforms has been indicated above, at the end of the discussion of each of the problems pinpointed. To reiterate these:

* ban on private medical colleges;
* compulsory continuing education of doctors;
* ban on irrational and hazardous drugs;
* ban on cross-prescriptions;
* standardization of medical interventions, of nursing homes and of professional charges;
* mandatory minimum medical record keeping;
* participation of private practitioners in National Health Programmes;
* proper training of paramedical staff and giving them a proper share in the prosperity of the clinic/hospital;
* tightening of professional self-regulation by doctors' associations.

The State has to take a much more active role in enforcing these reforms. Secondly, if the state pays for the medical care of its citizens, this single, powerful buyer can enforce the above reforms much more effectively. Patients are too vulnerable, powerless and scattered to put any positive pressure on doctors to reform the medical system. Thus a system of Universal Medical Insurance (UMI) in which every citizen is automatically medically insured (the state pays doctors' bills for all its citizens) is necessary to enforce these reforms. Such a system exists in Canada and Australia and is eminently practicable. This publicly financed, privately managed medical-care system would allow private practice and initiative. But, at the same time, it would also regulate it to safeguard the interests of patients of the nation and of rational, ethical practice in general. A large majority of doctors would benefit from it because of the security and the job-satisfaction it would provide to them. The question is, can we achieve adequate political mobilization and political enlightenment to bring about such a medical care system?

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THE PRIVATE MEDICAL SECTOR IN INDIA

There is no dearth of literature on the various issues pertaining to the planning and implementation of the health programme of the Government of India. But there are hardly any studies which have assessed the structure and functioning of the private health sector, (except the private drug industry) even though this sector is much larger than the public sector. According to different studies, private health expenditure accounts for 61% to 86% of the total health expenditure in India.(1) The private sector accounts for 73% of allopathic and a larger proportion of non-allopathic doctors, 56% of hospitals and 30% of hospital beds.(2) Different studies have reported that 55 to 83 percent of visits to health-centres for different illnesses are to the private doctors.(3) During the 7th plan period, the private health-expenditure, according to the estimate of Central Statistical Central Organisation (CSO), was Rs. 13821 crores, i.e., 1.69% of the Gross Domestic Period. This is more than thrice the expenditure (Rs. 3518 crores, 0.43% of GDP) on medical services in the state sector during the same period.(4) In spite of this overwhelming presence of private sector in health-care, there are hardly any systematic,published study of the structure, function, quality, role of private health sector in India.

The lack of systematic scrutiny of this dominant, vital sector in health care is all the more glaring when there is increasing talk about privatising the existing public sector. While studying the private sector, it becomes clear that it is more accessible to and popular with those who can easily pay its fees. However, in its present, almost totally unregulated form, it has many features which are inimical to the interests of the patients and the goal of rational and balanced development of the health services. Unless certain minimum reforms are undertaken and the sector brought under some regulation, the Indian people cannot hope to get good quality health care at an affordable price (paid directly or indirectly).

In this chapter, we would first go into the nature and size of different components of the private health sector in India. We would then discuss the problems and obstacles which stand in the way of providing good quality health care through the private sector, at an affordable price. At the end, we would broadly delineate the possible solutions to these problems.

At the outset it needs to be pointed out that there is a great paucity of relevant data and literature on the Indian private health sector (with the exception of the drug industry). Many of the statements made here are, therefore, not supported by adequate empirical data, but are based on personal knowledge and discussions with other knowledgeable persons in this field.

The private health sector in India consists of doctors, nurses, laboratory technicians, physiotherapists and nutritionists working in different private set-ups like: clinics, polyclinics, consulting-rooms, individually or jointly owned hospitals, so-called trust hospitals, pathology-laboratories, physiotherapy centres, diagnostic centres, medical insurance companies and corporate medical centres. Medical colleges for training doctors are an important part of the private health sector and will have to be included in our survey. The manufacture and distribution of pharmaceuticals and medical equipment, though a part of the private health sector, have been dealt with in the earlier FRCH volume of "The Health Status of the Indian People" (1987), in the chapter, "Drugs and Pharmaceuticals" .

Let us begin our discussion with the medical college, from where doctors - the most dominant section in the private health sector - begin their careers.

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1. UNREGULATED PRODUCTION OF DOCTORS & PRIVATE MEDICAL COLLEGES

Table Nos: 1 and 2 give the share of the private sector in the field of medical colleges, for allopathic and non-allopathic training, respectively. It would be seen from Table No. 1 that there was only one private medical college in 1950. There has been a slow but definite increase of this share of private medical colleges, from 3.57% in 1950, to 9.34% in 1979. Thereafter, there has been a rapid increase such that, by 1986, the share of private allopathic medical colleges had increased to 17%.

Though the Plan documents are clearly against any further expansion in the field of medical education, between 1974 to 1986, 18 new medical colleges were opened, 12 (i.e. 67%) of them in the private sector. Out of 98 Ayurvedic colleges, as on 1 April 1986, 55% were in the private sector. The corresponding figures for private Unani and Homeopathic medical colleges were 65 % (out of 17) and 75% (out of 105) respectively.

There have been many critical comments on the functioning of the private allopathic medical colleges. They offer low quality medical education at an exorbitant price. A student has to pay about Rs 3 - 4 lakhs (one lakh = 100,000) towards donation fees in such colleges. In Karnataka, in 1990, the government fixed the following fees for medical education in private medical colleges For Karnataka students : Rs 25,000/- per annum. For non-Karnataka students : Rs 60,000/- per annum. For foreigners : Rs 80,000/- per annum.(5) This was after a lot of hue and cry by the people against private medical colleges! Over and above this fee, these colleges were collecting donations from students at the time of admission. In 1993, the Supreme Court has in a landmark judgement, disallowed charging "capitation fee" or"donation" for giving admission to private medical colleges. Instead of arbitrary capitation fees, now the Supreme Court has ordered that half the seats in the reorganised private medical colleges would pay a fee equal to that in the Government medical colleges, and half the students in such colleges would pay a yearly fee of Rs. 1 lakh to 1.4 lakh. In case of Maharashtra, the Maharashtra Government has, in accordance with the Supreme court directive, fixed up the yearly fee in MCI - reorganised private medical colleges as Rs. 1.71500 for half of the seats. (6)

TABLE-1 '7'

MEDICAL EDUCATION INFRASTRUCTURE IN INDIA (1950-86)

(Allopathic doctors, Dentists & Nurses)

Reference Years	MEDICAL COLLEGES		DENTAL COLLEGES	NURSING INSTITUTIONS	
	No.	% Private		B.Sc.	General
1950	28	3.57	4	2	227
1951	30	6.66	4	2	246
1952	30	6.66	5	2	235
1956	46	6.52	7	2	239
1961	68	4.41	12	6	202
1966	89	8.98	14	8	246
1969	95	9.47	15	8	251
1974	105	8.57	15	8	262
1979	107	9.34	17	8	275
1983	111	10.81	25	8	324
1984	116	14.65	25	NA	344
1985	121	15.70	29	NA	374
1986	123	17.07	36	NA	386
1987	125	NA	40	NA	406
1988	128	NA	43	NA	421
1989	128	-	43	NA	466
1990	128	-	49	-	-

TABLE NO.: 2 (a)

MEDICAL EDUCATION INFRASTRUCTURE AS ON 1-4-86
(Doctors of Indian Systems of Medicine & Homeopathy)

(Figures in brackets give percentages)

	MEDICAL COLLEGES			ADMISSION CAPACITY			OUTTURN (1985)
	Govt.	Priv.	Total	Govt.	Priv.	Total	Total
1.AYUR-VEDA	44 (45)	54 (55)	98 (100)	1716 (44.2)	2166 (55.8)	3882 (100)	1813
2.UNANI	6 (35.3)	11 (64.4)	17 (100)	256 (44.4)	420 (55.6)	576 (100)	539
3.SIDDHA	2 (100)	- (100)	2 (100)	150 (100)	-	150	49
4.HOMEO-PATHY	26 (24.8)	79 (75.2)	105 (100)	1318 (22.3)	4595 (77.7)	5913 (100)	1769
Total	78 (35.1)	144 (64.9)	345 (100)	3440 (32.7)	7181 (67.3)	10521 (100)	3970

	Medical Colleges	Admission Capacity (as on 1.4.1989)
	Total	Total
1. Ayurveda	98	3947
2. Unani	17	665
3. Siddha	2	150
4. Homeopathy	97	5259

According to the official estimates, private colleges in Karnataka were collecting Rs 70 crores - Rs 80 crores every year

in the form of donations and fees!(9) In spite of such a huge collection, the quality of medical education in these colleges is poor. Out of the 13 private medical colleges in Karnataka only two have their own hospital facilities. (These two exceptional colleges were established long ago and do not belong to the new era of commerce in medical education). The students from the rest of the medical colleges are sent to government hospitals for clinical training. The Medical Council of India (MCI) has specified that for 100 students, the attached teaching hospital should have 700 beds.

However, the K.G. General Hospital used by M.S. Ramiah College has a total bed strength of only 313. Of the 11 departments specified by the MCI, this college has only four.(10) Similar has been the case with most of the other private medical colleges.

The MCI is against giving permission to sub-standard medical colleges, and has refused permission to 40 such colleges.(11) But it is sometimes pressurized by politicians to give `provisional permission'; later, such colleges continue in spite of lack of recognition by the MCI.

There are solid reasons for completely stopping these capitation fee private medical colleges. The availability of registered allopathic doctors has increased over five-fold, from 59,338 in 1950 to 3,30,755 in 1987. The availability per 100,000 population has increased from 16.5 to 42.6.(12) The availability of allopathic, ayurvedic and homeopathic doctors together has increased from 184,608 to 763,737 between 1961 to 1987. The availability of these three types of doctors per 100,000 population has increased from 42 to 98.(13) This means that there is one MBBS doctor per 2380 population, and one `graduate doctor'per 1,020 population.

Around 4,000 non-allopathic doctors and more than 13,000 allopathic doctors are added to this doctor population every year.(14) At this rate, by the year 2000 A.D. there would be around 500,000 allopathic doctors (after accounting for retirement and death) and more than 985,000 doctors belonging to these three systems of medicine.

Thus, even taking into account population growth, the availability of allopathic doctors and other doctors (from these three systems) per 100,000 population would increase to 51 and 101

respectively. With such a rapid rise in the availability of doctors, there is no need to increase the number of medical colleges in India. The paucity of qualified doctors in rural India is not going to be solved by adding more medical colleges to the existing ones; at least the proportion of allopaths practising in rural areas is not growing in spite of rapid growth of the total number of doctors in India.

Even though the number of allopathic doctors in 1981 was more than thrice those in 1961, yet their proportion in rural areas declined from 29.5% to 27.2% during 1961 to 1981. The proportion of allopathic and non-allopathic doctors together in rural area, has also fallen from 49.6% to 41.2%, during the same period. In general, there is extreme degree of inequality between urban and rural areas in India as regards availability of private health-facilities. According to the Enterprise Survey, 1983-84 by the Government of India, the estimated number of Non-Governmental Medical and Health establishments per million persons was 66 and 553 respectively for rural and urban India. Secondly, it is the better developed states that have a higher concentration of these enterprise.(15)

The supply of good quality medical care to rural areas is an extremely vital issue. But it cannot be solved by producing more doctors, especially in the private sector. More innovative, practical solutions have to be thought of. For example, well-trained and well-supported paramedics can tackle a large number of common medical problems. If the government takes up the issue of paramedics seriously, the requirement of doctors would go down substantially.

The most important argument against private medical colleges is that having spent Rs. 8 lakh - 9 lakh on medical education, the doctor is bound to recover this amount, (with interest!) from his\her patients by extracting more money in one way or another. Such doctors are more likely to employ unethical means for this purpose in an area of increasing competition, especially in the urban areas. Moreover, such doctors tend to gravitate more towards urban areas (as compared to other doctors) since there is not enough money in the hands of most of the rural patients. It is estimated that it takes more than Rs 10 crores to start a new medical college and Rs 2 crores annually to run it. In spite of their exorbitant fees, most private medical colleges do not spend such huge amounts to run the colleges and hence these

colleges are, by and large, sub-standard. Private medical colleges are no solution to the ills of the current medical system. On the contrary, they produce sub-standard doctors, coming from an elite background, who set up practice in urban areas and further lower the standard and ethics of medical care. These private medical colleges should, therefore, be closed down.

Non-allopathic medical colleges

No published information is available on the quality, performance and cost of private medical education in non-allopathic system of medicine. It is an open secret that most of the graduates from these colleges practice allopathy. This practice is mostly irrational, bordering on quackery, since they hardly get any proper training in allopathy. Non-allopathic systems of medicine do need support and encouragement, for they do play an important role in the delivery of medical care in India. But opening of non-allopathic private medical colleges is not the way to do this, since these colleges simply act as entrance gates for admission into the bazaar of medical care. If graduates from one system of medicine are strictly prohibited to use medicines belonging to any other system of medicine, and if violation of such a law is vigilantly checked and heavily punished, most of the private medical colleges in non-allopathic systems would close down.

Training centres for nurses and laboratory technicians are confined to the government sector. This is hardly surprising since this category of workers does not fetch a high price in the market.

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2. GENERAL PRACTITIONERS, CONSULTANTS, HOSPITALS

2.1. General Practitioners

There are no reliable All-India data that give the break-up of doctors into general practitioners, consultants and super-specialists. However, according to a recent survey of doctors in Ahmednagar district of Maharashtra, out of the 2740 qualified doctors identified in the district, General Practitioners accounted for 91.5% of the doctors and the rest were specialists.(16) This confirms the general impression that the Gp's are the most numerous sub-section of doctors. This picture is, however, changing gradually. As the competition amongst medical practitioners has increased over the years, more and more fresh graduates feel the need to do post-graduation to become consultants, in order to avoid the saturated field of general practice. In 1950, for 1,557 graduates passing from allopathic medical colleges, there were 88 (6%) post-graduates and dentists (separate figures for post-graduates excluding dentists are not available). In contrast, in 1979, the last year for which complete figures are available, there were 3,562 post-graduate degree earners as compared to 13,083 graduates i.e. 27% (17). However, this trend towards specialisation has not made an overall impact on the numerical preponderance of general practitioners. This is because of two reasons. Firstly, most of the non-allopathic graduates do not go in for post-graduation, but do general practice. They number around 450,000 and, with their inclusion, general practitioners as a sub-section of doctors, far outnumber consultants. Secondly, a substantial proportion of medical officers employed in Primary Health Centres and other government centres indulge in private practice, both officially and unofficially, and most of them are general practitioners.

There are quite a few number of "doctors" in the private sector in rural area, who do not have any qualification whatsoever. In a recent study in Madhya Pradesh, it was found that out of the sample of illness episodes treated in the private sector, 52% of these illness episodes in the rural and 18% in the urban area even treated by Licentiates and Registered Medical Practitioners RMP's.(18)

This broadly tallies with the earlier finding by J.F. Rhodes.(19) In Maharashtra, the Government appointed a committee to identify the unqualified quacks and to take action against them. 4971 such bogus doctors were identified.(20)

The classical general practitioner is a family physician who knows the family well, commands trust and respect of the family, is in the best position to treat routine health problems and give reassurance, which is one of the most important aspects of health care. Due to increasing competition and commercialization of medical practice, this category of `family physician' is on the decline. There is an increasing tendency amongst patients to literally shop at the bazaar of general practitioners, much to their own detriment, and to the detriment of the standard and ethics of medical practice.

Barring exceptions, general practitioners, as such, do not charge consulting-fees. They give medicines and injections, and charge for the treatment. This `charge for treatment' is more than the cost of the drugs used. Actually, this is illegal, since only registered pharmacy shops can sell drugs at a profit. Since the general practitioner recovers his consultation fee by indirectly selling the drugs at a profit,(21) there is a tendency to use cheaper drugs. Thus, many general practitioners, at least in Western India, buy medicines in bulk at a very cheap rate from the infamous "Bombay-market" and indirectly sell it to the patients with a substantial profit margin. These "Bombay-market drugs" do not have assured quality and this well-known fact is sidelined.

2.2. Consultants

These include clinical specialists and super-specialists from various branches of health science. Though they require a hospital attachment, very few set up their own hospital. The majority of them keep their clients in somebody else's hospital. There is a lot of competition amongst this sub-section of doctors in the cities, whereas in rural areas there is a great paucity of competent consultants and surgeons. In bigger cities there is the growing cancer of `cut-practice'; in a city like Bombay, it has become more or less a norm. `Cut-practice' means a consulting physician or surgeon or any specialist pays a certain part of his/her consultation fee to the doctor who refers the case to the specialist. Newer consultants in bigger cities cannot survive,at

least in the initial period of their careers, unless they offer this bribe to fellow-doctors who send their patients to him/her. They may not get any patients if they keep away from cut-practice. The initial investment for hiring a place and buying furniture and equipment for setting up a practice is a big problem for both general practitioners and consultants. The amount varies from about Rs 20,000 in a small town to a minimum of a Rs 200,000 in a city like Bombay. Such heavy investment after a prolonged training period converts medical practice into a business. Any reference to the poor people and their needs, therefore, fetches a totally apathetic disdain from a fresh practitioner in a big town.

Nowadays many fresh consultants settling in a large town, seek a part-time salaried appointment till their own private practice is well-established. This 'waiting-period' for settling down in private practice can vary from a few months to three years. Even after this period, there is a gnawing sense of insecurity due to the addition of new competitors, some of them being super-specialists. The development of ultra-modern, big trust hospitals or corporate medical centres provide job opportunities for a few elite consultants. But this is at least partly at the expense of the practice of the average consultants. The overall feeling amongst private practitioners, especially the consultants in cities, is one of uncertainty about the future, and hence a kind of obsession about current practice also. Doctors compare themselves with other richer sections in society and many doctors are unhappy about being unable to afford a car or to take a month off for a trip to Singapore; pleasure and happiness being measured in the fashionable consumerist terms.

How much do private practitioners earn? : Here again there are hardly any studies on this issue. In a study in Jodhpur, Rajasthan, in the early seventies, the average monthly income of private practitioners was reported as Rs.984 as compared to Rs.997 of doctors employed in government institutions.(22) A recent study estimated the income of private practitioners in Bombay (having more than five years of practice) to be much higher : Rs 18,333/-. Another recent survey in Delhi estimates average net income of doctors as Rs.39,160.(23) No general conclusions can be drawn from these studies. Figures can vary a great deal for other cities and smaller towns and amongst general practitioners and specialists; for older and newer generations. Nevertheless, this second study does give us some idea about the

earning of doctors in Bombay and Delhi. Two factors must be taken into account in assessing the adequacy of income of non-salaried people. Such professionals generally work for longer hours as compared to the employees in the organised sector; they have fewer holidays, no benefits like sick leave, privilege leave, provident fund, gratuity, house rent and medical allowance, leave travel concession, pension, etc. Nor does business offer long term security in this fast changing world.

On the other hand, unlike salaried employees, most of the businessmen do not pay full income tax and hence tax deductions are far less compared to their real income. The general, lay observation that doctors belong to the upper middle class and the fact that there is a heavy rush for admission into medical colleges indicates that choosing a medical career is still a paying proposition. However, doctors point out the need to take into consideration other factors like prolonged training, demanding nature of work, etc.

There is a need for more research to assess the income of various categories of private practitioners in different areas and to compare it with others on the basis of some established criteria.

2.3. Private Hospitals and Trust Hospitals

The accompanying Table No. 3 gives the number and proportion of private, voluntary, municipal and government hospitals, and their respective bed-capacities.

At the outset, it may be pointed out that the data in this table under-estimate the actual size of the private sector. Meticulously collected data in micro-research studies how that the private hospital-sector is much more predominant than what the official statistics indicate. For example, in Andhra Pradesh, official data say that on 1st January 1991, there were 266 private and voluntary hospitals and 11,103 private hospital beds. But a detailed survey undertaken by Andhra Pradesh Vaidya Vidhana Parishad revealed that there were 2802 private hospitals and 42,192 private hospital beds in Andhra Pradesh. (24) Even after taking into account the gross under reporting of private hospitals and private hospital-beds, Table No.3 shows the important trend of further privatisation in the hospital sector.

TABLE NO. 3 (25).

OWNERSHIP STATUS OF HOSPITALS & HOSPITAL BEDS

Year	HOSPITALS			HOSPITAL-BEDS		
	Govt.	Priv.	Total	Govt.	Priv.	Total
1974	2832 (81.4%)	644 (18.6%)	3476 (100)	211335 (78.5%)	57550 (21.5%)	268885 (100)
1979	3735 (64.7%)	2031 (35.3%)	5766 (100)	331233 (74.2%)	115372 (25.8%)	446605 (100)
1984	3925 (54.6%)	3256 (45.4%)	7181 (100)	362966 (72.5%)	137662 (27.5%)	500628 (100)
1988	4334 (44.1%)	5497 (55.9%)	9831 (100)	410772 (70.0%)	175117 (30.0%)	585889 (100)

There are no separate data on the proportion of trust hospitals. Most trust hospitals are not privately owned. But many of them, especially those set up in recent years, are basically privately controlled and commercially oriented hospitals. Most of them are now set up as trust hospitals primarily to take advantage of tax and other concessions, and to gain access to public money. They are, therefore, treated in this chapter as qualitatively not different from private hospitals.

Let us now delve a little into the functioning of private hospitals and trust hospitals.

Sub-standard small hospitals

Some general practitioners or consultants set up their own small hospitals. These hospitals are typically housed in small apartments consisting of a few rooms. Very few are built as hospitals with wide passages, good ventilation, in-house laboratory and radiological facilities. Small, 'apartment-hospitals', or 'nursing homes' are the most numerous of the private hospitals. Many such hospitals are set up by obstetricians. The bed-capacity of such hospitals is quite

limited, around 10 beds on an average. The quality of care in these hospitals varies tremendously and so do the charges. In Maharashtra, there is the Bombay Nursing Home Acts (1949) which is supposed to regulate the private nursing homes. Researchers have found that even in a city like Bombay, this Act is hardly enforced. It would be best to quote from their findings:

"Many nursing homes, hospitals, etc., continue to operate without being registered. Hospitals, nursing homes, etc., continue to exist under unhygienic conditions without basic amenities like water, proper ventilation, basic equipment, qualified staff, proper sanitation facilities, etc., The Act itself is deficient on various matters. It does not lay down minimum standards to be followed for setting up of nursing homes. The rules do not prescribe any standards for facilities. The rules have kept the criteria for staff, equipment, accommodation, etc., vague by just mentioning 'adequate'. It is not that this cannot be done, since there is a minimal standard to be followed by government hospitals and nursing homes."(26) As a consequence of a Public Interest Litigation filed by the Medico-Friend Circle, Bombay, the Bombay High court, directed the Bombay Municipal Corporation to appoint a committee to look into the implementation of the Bombay Nursing Home Act. As a member of the zonal sub committee, Sunil Nandraj found out the following picture in Bombay - In the Eastern part of Bombay, 62.5% of private hospitals were located in residential premises, 12.5% were in sheds which had only asbestos or tin sheds on the top; 8.33% had independent building of their own; 50% were in poorly maintained or dilapidated structures. Out of 22 hospitals conducting surgeries, only 15 had an Operation Theatre (O.T.) and in 7 of these 15, the labour room was combined with the OT. The average area of the OT was less than 100 square feet. 17 of these 22 Hospitals did not have a separate scrubbing room. More than sixty per cent of the hospitals surveyed did not have a minimum of 50 square feet space per bed. Ten out of 24 of these hospitals had non-allopathic doctors as house-physicians.(27)

It has to be specifically mentioned that the nursing staff of such private hospitals are, by and large, not professionally trained and are poorly paid. In the survey in Bombay just quoted, it was found that out of 24 hospitals surveyed, only 7 had a qualified nurse, that too, only 1 nurse per hospital. The nurses told the surveyors that they were paid Rs. 500/- to Rs. 700 per month. It may be noted that hospital owners earn more

than a minimum of net Rs. 20,000 per month as seen in surveys in Bombay and Delhi, mentioned earlier. Paradoxically, there seems to be a shortage of qualified nurses, since a job with the government, and more so in the Gulf, fetches a far higher salary for a qualified nurse.

Situation in other cities is probably worse. Only Delhi has a Nursing Home registration Act 1953. But even there, out of 545 nursing homes in Delhi, only 134 were registered under this act. (28) A small survey done by MFC, Bombay, showed that none of the 14 states who responded to a questionnaire sent by post had any act to regulate the functioning of the private hospitals.(29)

Medium and large hospitals

In addition to the very small private hospitals mentioned above, till the last decade, each town would have one or two medium sized famous hospitals owned by leading doctors of the town. Such hospitals were much better built, better equipped and at least part of the nursing staff was qualified. These once locally famous private hospitals, named after a particular leading doctor of the town, have now been left behind by a new breed private hospitals.

Since the last decade, the number of medium sized hospitals owned by groups of doctors have increased in every town. Large sized hospitals with a capacity of over a hundred beds are, however, beyond the means of individual doctors. Such hospitals have been built in the 'trust hospital sector', which is, in a way, part of the private sector. In rural areas medium sized or big, commercial private hospitals are a rarity. Many such hospitals have traditionally belonged to the voluntary sector. In general, the urban-rural disparity in the availability of hospital services is much more acute than the urban-rural disparity in the availability of general practitioners.

The cost of setting up even medium-sized hospitals has increased very rapidly due to the rise in costs of hospitals equipment and gadgetry. A modern hospital is now expected to have a range of sophisticated gadgetry, and the cost of these specialized equipments is well beyond the purchasing power of an individual doctor, even if he has a roaring practice.

Since it has become increasingly difficult for individual owners to build and run medium to large sized private hospitals, the trend has been increasingly towards setting up trust hospitals by leading doctors and other elites in order to gain advantage of tax laws and other concessions as well as access to public funds. These hospitals are much better built and provided for as compared to private hospitals. They attract the leading doctors in the area as consultants and a certain proportion of the patients are treated at a concessional rate or sometimes even free in these hospitals. Those belonging to the older era were, in fact, charitable hospitals, providing good expertise at concessional rates. Their staff was however poorly paid. In recent years, trust hospitals have become increasingly costly, thanks to burgeoning establishment expenses.

Sophisticated equipment installed in these hospitals require a certain minimum number of procedures to be done per week in order to recover the investment and to make up for the running expenses as well as provision for future equipment. Even though these facilities are subsidised through some donations, even then the 'concessional charges' are often too much for a poor or middle class patient. These hospitals have become good conduits for selling high-tech medical care to a broad section of the population. To attract expert doctors from the newer, highly specialized and professionally (read commercially) oriented generation of doctors, these hospitals offer attractive returns to these doctors; this is, of course at the cost of the average patient. Secondly, in an effort to regularly buy the latest gadgetry to upgrade the hospital continuously, the existing facilities are unnecessarily over-used by carrying out excessive investigations on the patient. The sellers of new technology have successfully hooked these hospitals in their dragnet and unless there is some rationalization of purchase and use of these equipments, there seems little hope that the patient's money would be spent where it is really required. Until then, Bombay Hospital, Jaslok Hospital and Hinduja Hospital would remain the ideal prototypes for all trust hospitals, and would increasingly become the conduits for accumulation of private wealth through public money.

2.4. The Corporate Sector

The development of the corporate sector is the most important development in the private health sector in the eighties. The

pioneer in the field was the Apollo Hospital in Madras. This multi-crore hospital with the latest diagnostic and therapeutic facilities and established with money raised from the share market has set the trend. The Apollo Hospital was set up in 1983, and was followed by diagnostic centres of the United Group, Standard Medical Group, Surlax Diagnostic Ltd, etc. Corporate houses in India are joining this attractive business one after another. Within a period of just two years, between 1984 and 1986, Rs. 200 crores were invested in these corporate ventures. This rapid expansion is due to the high profitability of such ventures. For example, the United Group recovered its investment on a brain-scanner within two years.(30) It is no surprise that by 1970 many more corporate houses were in this field. Chhabrias, Goenkas, Birlas, Modis, Oberois, Singhanias, Nandas, Hindujas ... have all entered this business.(31) The non-resident Indian doctors have also linked themselves with this trend. For example, Kovai Medical Centre and Hospital in Tamil Nadu has been promoted by a group of NRI doctors. This company has set up a 250 bed hospital complex at Coimbatore.(32) The public sector institutions are helping these ventures. For example, the Andhra Pradesh State Financial Corporation has lent Rs 7.35 crores for the Rs 20 crore ultra- modern CDR Hospital in Hyderabad; whereas the Delhi Administration was to buy 26% of equity-shares in a joint sector company - Indraprastha Medical Corporation Limited - in Delhi, with the Apollo Group.(33) These corporate ventures are seeking foreign collaboration also. For example, Peerless with Hospital SA (France) Collaboration; UB Group with Pikker International, Standard Organics with Welcome Foundation ....(34) After the Apollo hospital, nine more corporate hospitals involving an investment of around 120 crore rupees are in the pipeline, in Hyderabad, city alone! A journalist reported - "More funds have been ploughed into this sector than any other segment of industry in Andhra pradesh in the past two years... (35) "These corporate hospitals have been set up with the primary motive of earning profits. Dr. Dayakar Reddy, the leading promotor of the CDR-hospital in Hyderabad, confided with a journalist that the break-even point of their hosp;ital would be at an earning level of Rs. 20 lakh per day. (!) (36)

Says Sangita Reddy, Chief Executive of Apollo Hospitals in Hyderabad, "there is aggressive marketing now because of the need to ensure quicker returns on the investment and debt servicing". (37) The financial implications of such ventures for patients can be easily surmised. For the national economy also, these hospitals would add to the problem of balance of payment. High-

tech medicine means a lot of import of the medical equipment. Such import reportedly increased from Rs 20 crores in 1980 to Rs. 65 crores in 1986-87 and was expected to rise by 20 per cent per year in the immediate future.(38)

The cost of medical care in these profit-oriented corporate high-tech hospitals is, of course, beyond the means of ordinary citizens. They thus cater primarily to the elite in the country. The joint sector projects are supposed to treat 40% of the patients at either concessional rates or free of charge. But how much of this service is available to the poor common man without any connections, is a moot question.

2.5. Private Medical Insurance

The other new development in this field is the rise of medical insurance and the collaboration of medical insurance with the corporate hospitals. The General Insurance Corporation, one of the insurance companies in the nationalised sector, started its 'Mediclaim' policy in 1986. Aimed at the middle and upper classes, medical insurance was slow to pick up initially. Thanks to the collaboration with private corporations like Apollo in Madras, Batra Hospital in Delhi, Hinduja and Breach-Candy Hospitals in Bombay, an increasing number from the elite are looking for medical insurance cover through these sophisticated hospitals. By the end of 1988, the four insurance companies reported 138,157 health insurance policy-holders who annually pay Rs. 12 crores towards premium.(39) Thanks to the insurance schemes, these hospitals are getting some regular business since the patients are now more than willing to get investigated because the cost is to be borne by the insurance company. The insurance companies initially did not have a good screening system and hence paid for some unnecessary medical interventions. Insurance corporations would, henceforth, take care to see that they do not end up in losses. If one considers the overall balance, it would seem that this tie-up is partly tapping and partly creating a market in health care amongst the middle and upper classes. It is creating a culture of over reliance on investigations and 'over-interventionist' medical practice. Though health insurance in itself is a positive step forward, in its commercial form, it is diverting potential savings into the pockets of the corporations and the elite specialist doctors. The sophisticated technology brought by these corporations can be a great boon for the patients if it is used judiciously, and only

when really necessary. The whole question is, do profit-oriented, powerful corporations with the aura around ultra modern technology and the authority of the doctors at their command, use these technologies for relief of human sufferings or for profit making? Suffice it to say that with the rise of the corporate sector, the cycle in health care does not start with a trained medical being and a sick person in search of each other, but with an investor in the share market in search of profitable investment, the availability of newer medical technology and a market in medical care, being merely an 'attractive field of investment'.

2.6. Role of Government Policy

The government has always emphasized the importance of preventive and promotive health services. But the health department cannot provide food, water sanitation to the people. Due to the utter neglect of proper planned development, the basic causes of ill-health - poverty, malnourishment, low living standard - in general have remained unattacked. Secondly, at the level of the actual delivery of health-care services,this correct emphasis on prevention is, however, at the expense of symptomatic and curative care in the state health services. The state health services are confined to a few national programmes to control diseases such as malaria, leprosy, tuberculosis, trachoma, goitre, etc. Maternal and child health programme, with its emphasis on immunization and contraception, is also an important feature of the government health services. For a host of other illnesses and health problems, people have to go to the private practitioners since, as a matter of policy, the government has decided to neglect curative services for most of the health problems. This opens wide the gates for private practice. The government policy has thus led to the growth of the private sector in health services.

The quality of private practice is also affected by the government policy. There is absolutely no attempt to stop medical practice by unqualified persons; nor any attempt to prohibit allopathic prescriptions by non-allopathic practitioners and vice versa. The rural people are thus left to the mercy of unqualified practitioners who use allopathic drugs in the most irrational way. There is no dearth of qualified doctors in the country. The government used to make it compulsory for a fresh MBBS graduate to work on a bond service of two years (generally

in the rural PHCs) after graduation in the government sector. But now this practice has been abandoned since the government cannot absorb 12,000 to 14,000 fresh graduates every year in its service. As a result, all the public money spent on training of doctors contributes to the growth of the private practice.The cost of training one MBBS doctor works out to around Rs 4 lakhs !(40) All this expenditure is a help to the private sector for supplying it with trained doctors for private practice.A large number of doctors migrate abroad every year.Their number has swollen from 810 per year in the First Plan period to 4,637 per year in the Sixth Plan period.(41)

For the Sixth Plan period, the number of doctors migrating abroad was 39.6% of the out-turn of allopathic doctors. The government is thus spending Rs. six crores every year to train doctors for health services of other countries! This `over production' of doctors (not in relation to the needs of the Indian people but in relation to the capacity of the government health services and the urban market to absorb them) is a case of ineffective planning. The government policy has thus supplied/trained doctors to the private sector and has created a potential market for private practice in health services by its neglect of curative services in the state-sector.

The economic policy has created a small section of middle and upper classes, which is prepared to spend money on private practitioners. Thanks to the `liberal' economic policies in recent years, the elite in India has accumulated enough money to spend on regular `health check-ups'. A potential market has been created for `sophisticated diagnostic centres'. It was left to the clever corporate-managers to convert this potential market into an actual one. Even this has received direct help from the government. For example, import duties on medical equipment were reduced from 107% to 40%.(42) Concessional loans have been given to them. For example in 1988, the Apollo Hospital received concessional loan of Rs 2 crores (43) from I.D.B.I. for its project in Madras.

We have referred earlier to the direct partnership of public bodies in corporate health projects. There are indirect ways in which government decisions have helped this business. For example, in July 1985, the Finance Minister declared that reimbursement of medical expenses will no longer be considered a pre-requisite, meaning thereby such expenses can be shown in the

expense account, and not added to taxable income.(44) Such decisions encourage businessmen to spend money at the corporate health centres, thus increasing the latter's market.

It is strange that a government with the declared aim of attaining socialism and committed to the development of weaker sections, should consistently help the accumulation of private wealth, and lately, the growth of the corporate sector. When the poor people of India, especially in the rural areas are unable to get even basic, elementary health care, when majority of the people are getting irrational drug prescriptions, unleashing such a powerful force in the totally unregulated market of health care in India is a highly questionable strategy from the point of view of the declared aims of the state.

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3. THE PROBLEMS GENERATED BY UNREGULATED PRIVATE HEALTH-SECTOR

It has now become fashionable to criticize the public sector and praise the private sector.It is true that the functioning of the public health sector has many problems like bureaucratic red-tapism, apathy towards patients, etc. But it needs to be pointed out that the private sector also generates so many problems that it needs to be regulated to protect the interest of the consumers. Let us see the nature of these problems in the field of health care.To begin with, a few lines about the special features of the health services as such, whether public or private.

3.1 Special Features of Health Care Services

Health care services are different from other services because the doctor directly acts on the consumer's body and mind and hence, any defect in the health services being provided affects the consumer in a much more threatening way than say defective stitching of a shirt or a defective telephone service. In spite of the sensitive and crucial nature of health services, patients are unable to bargain for quality and price of the services rendered because, in the doctor-patient relationship the patient is at the receiving end of the power-equation.This is due to the fact that the patient approaches a doctor when he/she is in need of relief from physical/emotional distress. It is as much of seeking help as of buying or seeking a service. The relief from pain and suffering at the hands of a doctor naturally evokes a different kind of response from the patient than a simple 'thank-you'. The patient is grateful to the doctor and is many times wonderstruck, thanks to the mystification of medical science. Secondly, the doctor legitimately probes the patient's body and mind to arrive at a diagnosis and this complete exposure of one's person to the doctor has its own implications for equality in the doctor-patient relationship. The very act of undressing before the doctor sets up an unequal power relation. Thirdly, the doctor has the power to declare a person healthy or sick, sane or otherwise; and hence the declaration of the result of the doctor's examination has a different significance than knowing, after purchasing a ticket, whether a bus is going to start towards the destination on time. Fourthly, since the response of the human body to therapy cannot be predicted as in a machine, the doctor's performance is difficult to judge on the basis of its results in a particular episode of illness. Trust (though

not 'blind-faith), in the doctor is an important aspect of the doctor-patient relationship and the patient is not interested indisturbing it, so long as adequate relief is obtained. Moreover patients are afraid to bargain or to show a lack of trust, because of the fear that this might adversely affect the doctor's attitude towards the patient, and in turn, the quality of health care provided. Medical ethics tend to prevent the misuse of the power doctors have over their patients. It is, however, in a way, a matter of discretion on the part of doctors whether medical ethics are followed or not. Medical ethics are to be monitored by Medical Associations. Patients do not have a say in it. In developed countries, patients now have some legal rights like right to informed consent, right to refuse treatment. But even in the U.S. these rights are not generally enforced. For example, a 1983 American study found fewer than five patient refusals of any procedure during the course of 100 days of patient treatment.(45) In India no such special right of the patient exists, even on paper.

When health services become a commodity, this basic power equation undergoes some modification. On the one hand, competition amongst doctors gives the consumer a kind of choice to choose between doctors. Doctors must earn a reputation to attract patients. But on the other hand, various commercial incentives offered by drug companies and the pressure of seeking clients in a competitive market tempt the doctors into unnecessary and unscientific interventions.

Let us now see how, in India, the doctor-patient relationship has taken a peculiar shape in the private sector.

3.2. Irrational Drug Use

The most important problem with health care in India, apart from its urban/rural disparity, is the predominance of unscientific practices. This phenomenon is much more present in the private sector, though is not exclusive to it. This can be seen from some concrete indications.

Drug treatment is, of course, the most important part of modern allopathic practice in non-surgical cases; such cases being predominant. Most of the drugs in India are in the form of drug combinations and most of the drug combinations marketed in India are irrational, some are even hazardous.(46) These irrational

and hazardous drugs are mostly prescribed in the private sector since, after all, the majority of the patients in India go to the private practitioners. Secondly, in most of the government health centres, drugs are used from a select list of essential drugs. These lists, especially in recent years, consist mostly of rational drugs. Medical officers in government health centres may not be more keen on using rational drugs, but they have to choose from this list and hence drugs used in the government sector are by and large rational. (However, due to corrupt practices, drugs used in public health sector are sometimes sub-standard). As in private practice, drugs are many times used by government doctors without accurately diagnosing the illness and hence there is irrational use of rational drugs. But in private practice, in addition, the drugs used are themselves often irrational. Given the inadequate supply of drugs to public dispensaries and hospitals, government doctors do prescribe drugs to be bought by the patients. Many government doctors officially and unofficially do private practice. Such prescriptions, many a time contain irrational drug combinations. But, on the whole, private practice forms the bulk use of irrational drugs. That the use of irrational or hazardous or unnecessary drugs or injection is much more common in the private sector is corroborated by the preliminary results of a study of prescription practices in a typical district in Maharashtra. The preliminary results of this study being conducted by FRCH, in Satara district, are given in Table no. 4 below :

TABLE NO. 4 ('47')

COMPARISON OF PRESCRIPTIONS IN PRIVATE AND PUBLIC CLINICS

% of prescriptions containing one or more	Public Clinics %	Private Clinics %	Average %
a) irrational drug combination	9.6	30.9	20.3
b) hazardous drug	7.4	14.6	11.1
c) unnecessary drug	46.3	56.7	51.0
d) unnecessary injection	24.6	25.5	25.7
Number of Prescriptions studied	1814	1688	3502

Unnecessary use of injections and intravenous infusions is the most glaring example, yet the second most common unnecessary intervention resorted to primarily by general practitioners. The uneducated people especially have a kind of superstitious faith in the `prick', thanks to the deliberate misuse of the prick by many doctors. Now a stage has come, when most patients (except children) are not satisfied, unless a prick is given. Since there is no tradition of paying separate consulting charges to a GP, the latter finds injections as a good pretext for charging sufficiently and collecting indirect consulting fees. Mere dispensing of drugs would not fetch such fees! Why this sorry state of affairs?

Firstly, the drug industry, dominated by profit-hungry foreign and Indian monopoly companies is bent upon dumping unnecessary, costly, and unscientific drug combinations in the Indian market. Secondly, patients expect very quick relief, having a kind of magical faith in modern technology. This faith has been partly due to unscrupulous practitioners who very liberally use steroids to achieve miraculous symptomatic relief at the expense of rational therapeutics as well as the long term interests of the patients. A vicious cycle of irrational practice and `irrational expectations' from patients has set in.

The patient is looking for relief at the earliest because he/she does not want to lose economically by staying in bed. Patients expect, and are many times promised, quick relief whatever may be the nature of the illness. The way out of this vicious cycle is health education of patients and enforcement of rational therapeutics. However, most practitioners are not interested in educating people about these irrationalities. This is partly because drug companies bribe them through free samples of medicines, gifts and other material incentives. Moreover, the ignorance of patients is an important asset to the thriving unscientific medical practice. When superior clinical acumen and intervention are not the mode of competing with other doctors, patients are to be kept happy with impressive looking capsules, bottles, injections of various names, shapes and colours. Competition within the framework of irrational practice needs a plethora of irrational drugs under different brands and packings. Thirdly, inadequate knowledge of scientific medicine is an important contributory factor. Lack of proper continuing education of doctors after graduation and the misleading propaganda by the drug companies make the average Indian doctor

more of a clever businessman than a practitioner of scientific medicine. Let us delve a little further on this important point of lack of continuing medical education.

3.3. Lack of Continuing Medical Education

Though a majority of cases in general practice are relatively simple to diagnose and treat, a certain section of cases does indeed require a much larger knowledge base and experience for diagnosis and treatment. Many serious and complicated disorders are deceptively simple in their presentation and a good practitioner has to keep in mind a number of possibilities even in routine practice. Good medical practice is, indeed, an intellectually demanding work, since a large number of variables have to be analysed in a matter of minutes and on the spot, to arrive at a diagnosis and the precise mode of management. Secondly, mere reference to old text books is not sufficient since medical knowledge is changing so fast, especially over the last 40 years. Medical practice is one field in which even routine work (like treating diarrhoea or tuberculosis) requires periodic updating of knowledge. Yet it is precisely the area of Continuing Medical Education (CME) that is the weakest part of medical education in India. Let us see how.

The most widely distributed source of CME for MBBS graduates is the Journal of Indian Medical Association (JIMA). But it reaches only to the members of the IMA, which means only 80,000 out of about 3.5 lakh registered allopaths.(48) Even though general practitioners constitute the majority of doctors in India, this journal contains only 3-5 pages for the section `GP Forum', out of around 25 pages of scientific material in each issue. Moreover, it is a moot question as to what percentage of IMA members actually read this journal. Most general practitioners rely on the biased promotional literature supplied by medical representatives of drug companies and the oral `detailing' by them. Apart from this journal, IMA organises lectures and discussions on clinical scientific topics. But generally only 10% to 20% of members in a bigger town attend these programmes. It would not be wrong to say that not more than 5% of allopathic general practitioners participate in systematic Continuing Medical Education. Physicians, surgeons, paediatricians, etc., have their own associations, journals, CME-activities; CME amongst these post-graduates is better but there are no data about its extent and quality.

CME amongst non-allopathic graduates who practice allopathy is almost non-existent. Very few of them become associate members of IMA and hence receive the Journal of IMA, and attend IMA programmes. IMA branches and programmes do not exist in very small towns where such practitioners predominate. The result is that the treatment at the hands of these practitioners is very much heavily influenced by the propaganda by drug companies. Since they have hardly received any training in modern, scientific allopathic clinical medicine, there is barely any clinical examination and the drug treatment is based mainly on symptoms. A conscious doctor reports: "I see that simple malarias continue to get antibiotics for weeks and weeks, fungal infections of groin branded as STDs and patients bled for money, uterine irritability in pregnancy given mathergin injections ..... acute meningitis cases being given fast infusions causing deaths ....."(49)

Gross irrationalities in drug prescription are not confined to the untrained / half-trained alone. Many MBBS doctors and even post-graduates indulge in such prescriptions and remain unmonitored. In an interesting report, prescriptions by a RMP (Registered Medical Practitioner) and by a MRCP doctor for the same patient, for the same episode of illness were compared and found to be equally bad and unscientific.(50) The FRCH study in Satara district quoted above, showed that out of prescriptions of post-graduate doctors, % were grossly irrational, % contained irrational drugs (51)

Treatment of tuberculosis is a classic example which demonstrates how the lack of adequate knowledge of diagnosis and treatment of tuberculosis, and the narrow, myopic interests of some selfish private practitioners can lead to a callous neglect and even exploitation of the poor, ignorant patients.(52) A study in Valsad, Gujarat, concludes: "Our data on the other hand show that those who do go quickly and directly to the District Tuberculosis Centre (DTC) have a comparatively better chance to recover fully from TB .... the diagnostic and advisory activities of DTC were shown to be far superior to those carried out by most private practitioners".(53)

Even in a city like Bombay it was observed in a study that private practitioners do not treat their patients properly. The World Health Organization has prepared eight standard regimens of drug treatment of tuberculosis. Any one of them can be used

depending upon the convenience and financial resources at command. In this study, it was found that the 100 private practitioners studied used 80 different regimens, only 4 of which matched with one of the 8 standard regimens recommended by WHO.(54) Whereas the cost of the 8 standard WHO regimens varied from $14 to $67, with a mean of 37, the cost of 80 regimens prescribed by these 100 private practitioners varied from $7 to $260, with a mean of $104.(55) Incidentally, similar irrationality was found in the use of drugs for treatment of leprosy by private practitioners in Bombay. Some 106 private practitioners were studied from three different areas in Bombay. It was found that only 13%, 24%, 8% of general practitioners in three areas followed the standard drug regimen recommended by the W.H.O.(56)

3.4. Other Irrationalities

Irrationalities in private practice are not confined to drug treatment alone. They are present in all aspects of medical care - diagnosis, investigations, surgery, nursing, etc. But in India, there is hardly any documentation of the state of affairs, though they are well-known within medical circles. We will mention a few discreet cases that have been documented.

With the doctors of a medical college as his eye witnesses, a journalist collected nine samples of his blood and gave them for testing at seven private laboratories in Thiruvanthapuram (in Kerala) for estimation of blood sugar and blood urea levels. There was little agreement in the results! Two blood samples of the same blood were given to a single laboratory for estimation of blood sugar and blood urea levels. The results were : 85 and 75 mg percent for blood sugar and 21 and 32 mg per cent for blood urea. The white blood cell count of one sample of blood sent to three different laboratories was 5000, 6200, 8680 per cm. respectively! (57)

Maintaining good standards requires use of standard equipment and chemicals; careful calibration; maintenance, as well as proper training and meticulous work ethics. There are reputed private laboratories in every town but many private laboratories do not aim at quality work. Is this because some private practitioners are not really interested in the results but do investigations to get a `cut' from pathologists?

'Cut-practices' are resorted to in case of other investigations also. A conscientious physician in Pune has gone on record in indignantly complaining about representatives of a C.T. Scan Centre offering him commission for sending patients to the centre for C.T.Scan.(58) Such cut-practices by C.T. Scan centres in Bombay are an open secret in medical circles. Dr. Arun Bal, a conscientious surgeon in Bombay, complained to the Maharashtra Medical Council, that a "diagnostic Centre" in Bombay sent him a cheque of Rs. 30/- along with a "thank you" letter, assuming that one of Dr. Arun Bal's patient who went to the diagnostic centre was directed by Dr. Bal to go to this centre. (59) Conscientious doctors in personal discussions say that "cut practice" especially for unnecessary surgeries is increasing fast in district places and surrounding villages.

In the developed countries, there have been studies to find out whether a particular invasive procedure is being done excessively in a hospital or area and the reasons for it.(60) But in India, no such data are available. However, it is an open secret that certain surgeries are done unnecessarily by some surgeons. Typical examples are: tonsillectomy, appendicectomy, caesarean section and hysterectomy. To this list may be added the new cardiac procedures. According to a senior cardiac surgeon in Bombay, 40% of coronary angioplasties and 20% of coronary bypass surgeries done in Bombay are unnecessary.(61) With the advent of high-tech, high-cost, profit-oriented corporate sector in health, it is no surprise that in the absence of any social control, so many unnecessary procedures are done for making money.

Cities like Bombay, Calcutta, Delhi are notorious for mushrooming of substandard private hospitals which are set up not with the aim of doing 'medical-practice' with its accompanying code of ethics but to merely do business. In Calcutta, the situation was so bad that in response to a petition by an advocate in the Calcutta High Court, the Speaker of the West Bengal legislative Assembly set up a Committee in 1985 to prepare a report by visiting private nursing homes in Calcutta. This report had recorded lack of adequate floor space, ventilation, lighting, water, bathroom facilities and even qualified doctors and nursing staff in many private nursing homes. It had also recorded some irregularities in these hospitals. But no action was taken.(62)

In Bombay, the case of Ms Yasmin Tavaria and Medico-Friend Circle, vs Petit Parsee General hospital has brought forth the

question of standards of medical practice in private hospitals in Bombay. Eruch Tavaria died in this hospital in August, 1989 due to the administration of blood belonging to a wrong group. The attending physician was a homeopath, not qualified to give allopathic treatment. This hospital was reported to have employed five more homeopaths, one of them in the intensive care unit.(63)

There are increasing number of press reports of court cases against doctors for medical negligence and malpractice.(64) These cases are only a small fraction of actual incidences. This is because of the fact that most patients in India do not go to the courts even if they are aggrieved. They curse the doctor, but do not take any legal action.

There are certain areas in which unethical behaviour has become the norm. For example, kidney-donation by an unrelated live donor has become a regular business in which some private hospitals and their doctors play a nefarious role.(65)

Even if amniocentesis for prenatal diagnosis of the sex of the child has been banned in Maharashtra in 1988, it is an open secret that it is clandestinely done in Bombay by many doctors.

Worse is the practice of some private blood-banks. This has been brought to light by a writ plea by Dr. I.S. Gilada of the Indian Health Organization, Bombay. This writ plea was filed when 40 of the 300 persons selling their blood to Bharat Serum Pvt. Ltd., were randomly checked at the J.J. Hospital's AIDS Surveillance Centre, and 35 were found to be AIDS-positive.(66) Unless there are statutory regulations to control the functioning of private blood banks, the spread of this killer and other diseases and the reckless exploitation of blood sellers and the consumers would continue. (67).

The discreet reports of irrational therapeutics and malpractices quoted above are not isolated instances, but a part of a definite and growing trend, well-known in the concerned circles. That these incidences are not systematically documented reflects the poor state of documentation and research of relevant happenings, as well as extremely low consumer resistance in this field in our country.

The bureaucratic apathy and callousness often seen in public health services is, of course, not seen in private practice. But

since private practitioners, like other professionals, are interested primarily in their personal gains, there is a tendency to use all means to gain ascendancy over others. This is especially true in recent years due to the fast growing competition amongst doctors. This unregulated play of the law of the market, coupled with high pressure salesmanship of the drug industry and the growing, but as yet very low consumer resistance to manipulation, has led to pervasive irrational practices the field of private medical practice.

3.5. No Professional Self-regulation

A profession differs from a trade in that it is primarily based on a certain skill and not capital, and is regulated by a code of ethics. Ethical behaviour is of course not enforced by law but it is up to the association of professionals to oversee the ethics of the profession and to determine and maintain professional standards. The Indian Medical Association, the parent association of doctors in India, is not a particularly strong body and secondly, it does not have statutory powers. As mentioned earlier, only 25% of allopathic doctors are its members and an even smaller percentage of these participate in whatever programmes of continuing medical education that are taken up. I.M.A. does not set up professional standards, let alone enforce them. There is no mechanism to prevent or at least discourage sub-standard medical care. Everything is left to the play of market forces, even though a profession is not supposed to be completely regulated by the market. The Medical Council of India is the statutory body to maintain medical ethics. But it is quite inactive and somewhat powerless also. Perhaps the situation is as bad or even worse in other professions, but maintenance of professional standards and ethics is much more important in the medical profession since it directly deals with human life and well-being on a continuous, daily basis. There has to be some effective mechanism of ensuring professional standards and ethics in the medical profession.

The Consumer Protection Act-1986, is meant to help the consumer to seek redressal and compensation in case of deficiency, negligence, or cheating etc. in the sale of goods or services to a consumer. All professionals including doctors are covered in this Act. Doctors have opposed their inclusion under this Act and the Indian Medical Association has gone to the Supreme court challenging this inclusion. The various arguments put forth by

IMA in favour of exclusion of doctors from CPA are untenable. (68) Instead of opposing this inclusion, those doctors who are interested in ethical, rational practice, should look upon CPA as an opportunity to bring about improvements in the medical profession. Law expects doctors only to give "reasonable-care" and not success, leave aside cure.(69) In-spite of giving "reasonable-care" if any mishap occurs, the doctor is not legally liable. The CPA has not changed this concept of doctor's legal liability. If what is "reasonable care" for different diseases, especially life-threatening situations, is laid down by local professional medical organizations, (standards would change, depending upon the type of equipments and expertise locally available and on the local socio-economic conditions) there is no reason why the judiciary, including the Consumer Redressal Forums, would not accept these reasonable standards. Those doctors who would follow these minimum standards, would be legally safe. The patients would also benefit from such standardization, because, today, there is a lot of arbitrariness in the way many doctors use different modalities for diagnosis and treatment of various health-problems. Secondly, in the wake of the CPA, there would be unnecessary investigations to arrive at a diagnosis partly in order to "play-safe", and partly out of some kind of vengeance about the CPA. The Health-Committee of the Lok-Vidnyan Sanghatana, (the People's Science Organization in Maharashtra,) has, in the Pune city, taken initiative in preparing minimum standards for check-up for anaesthesia before surgery.(70) Such standardization should take place for other potentially life-threatening medical interventions and be adopted by all doctors organisations.

3.6. Lack of Rationalization of Doctor's Fees

Today, there is no principled basis for the level of fees to be charged by the doctor. The amount is basically decided by the law of the market. Since the market conditions are a little capricious, the charges vary tremendously. A paediatrician in a small town may charge Rs 20/- for consultation, as compared to Rs 100/- in a city like Bombay. Hospitalised patients are charged @ Rs 50/- to Rs 100/- per day as consulting charges by consultants. This is despite the fact that the doctor hardly spends five minutes per visit as compared to about half an hour during the initial consultation. Similarly, a surgeon's operating charges are also arbitrary. For example, charges for caesarean delivery may vary form Rs 500/- in a small town to Rs 5000/- in Bombay.

The capacity and willingness of the patient to pay, and the image of the doctor in the town determine the charges, rather than the knowledge, experience of the surgeon and the type of surgery involved.

3.7. Paucity of Record Keeping

General practitioners and small hospitals generally do not properly record even their clinical findings, leave alone maintain other records such as number of patients attended to in a day, their distribution; muster-role and pay role for assistants; income and expenditure. Larger hospitals do keep some clinical records, but they are hardly ever analysed. Secondly, the clinical record is not available to the patient as a matter of patient's right. There is, therefore, no question of any medical audit.

3.8. Urban-rural Disparity

In sub-section 1 we have seen the urban-rural disparity in the availability of private doctors.

As remarked earlier, this disparity is mainly due to the disparity in the availability of market in these two areas. Secondly, doctors are, by and large, brought up in cities and are unwilling to go to rural areas. Apart from lack of civic amenities in rural areas, lack of elite company and good educational facilities for their children also matter in the choice of place of practice by doctors. These are genuine problems of a city-bred person, but the most decisive factor is lack of sufficient purchasing power in the rural areas. Since private practice is primarily geared to acquiring income for the practitioner, the urban-rural disparity of qualified, good quality private practitioners is going to be an essential feature in India, if we rely more and more on private practice as a means of supplying health care to the rural population.

3.9. Lack of Preventive Measures & Health Educational Efforts

Private practice is, by its very nature, confined to individualised relation between a patient and a doctor. So long as the patient is relieved of sufferings, the job of the private practitioner is over. But disease-production is a socially mediated process. For example, persistently high incidence of

water borne diseases is due to lack of proper facilities for water and sanitation in a whole area and not merely in a house. If these diseases are to be prevented, the doctor who has the knowledge of mechanisms of spread of such diseases must take the initiative to share it with the people and the leaders of the community. It is only then that collective action to prevent water borne diseases can be taken up. This is true not only for infectious diseases but also for diseases like cancer, obesity-induced diseases and occupational health hazards. The epidemiology and preventive measures of most of these diseases is known, but private practitioners would not normally take the initiative in preventing diseases since his/her interest is to treat individual patients or families. Such initiative can be taken by an association of doctors. But the community of private practitioners would be adversely affected if the prevalence of diseases goes down since their practice is dependent upon the prevalence of diseases. Secondly, there is already so much competition amongst private practitioners that it is difficult for them to come together to engage in an activity which would further reduce their market. In spite of this, some doctors and their associations do take up on their own, or co-operate with the government for immunization programmes and other such activities. But this is philanthropy (and therefore rather uncommon) and not an essential part of private practice.

Health education about precautions to be taken during illness, about prevention of illness and about activities to be taken to promote health are an important part of health care delivery. Private practitioners would be interested in doing health education about the first aspect (precautions to be taken during illness). The other two aspects, though quite vital, would not ordinarily be taken up by private practitioners. This is despite the fact that prevention is better than cure. In non-infectious diseases like high blood pressure, ischaemic heart disease, addiction to alcohol and tobacco, cancer, occupational diseases, etc., prevention is, in fact, the most important since not much can be done to cure the patient once the disease sets in. But the very nature and basis of private practice is not geared to preventive health education, especially on a social scale. It is therefore not surprising that there is so little health educational activity on a social scale in the private sector. Associations like the Diabetic Association of India does health education about diabetes, individual doctors do write in the lay press, have authored books on health for lay-people, but these

are exceptions. Secondly, they reach a very limited population. For example, the IMA publishes two magazines: `Your Health' and `Apka Swasthya' for lay-people, but they are not at all widely circulated; in fact, they are hardly known.

When doctors do engage themselves in health education they tend to commit typical mistakes. For example, the patients - the victims - are typically blamed for bad habits like smoking, drinking, but the tobacco and alcohol industry - the real culprits - would be spared. There would be focus on the immediate cause of the disease process at the biological level like: `germs' or `high blood cholesterol' without reference to the broader issue of budget for water and sanitation or sedentary, consumerist life-style, copied from the West. There would be a series of `do's and `don'ts', without explaining the basic rationale behind such instructions. Finally, there is the familiar exhortation to `see your doctor regularly for health check-ups'. The overall impact of such `health education' is to narrow down the concept of the disease process to merely its biological aspects and to ignore the broader social causes; to mystify medicine; to exaggerate the importance of post-facto corrective technology and, therefore of the clinician. Whether the doctor is aware of it or not, such `health-education', more than anything else, expands the market of medical care.

3.10. Poorly Paid, Unqualified Staff

A good assistant is of tremendous help in medical practice. But most of the assistants employed in private practice, except those in large hospitals, are unqualified. This is just to lessen the expenditure on wages. The law now regards hospitals as industries and the Minimum Wages Act is applicable to hospitals, dispensaries, laboratories. This law categorises medical assistants into four categories, viz. skilled, semi-skilled, unskilled, supervisory, and prescribes minimum wages for each of these categories. Generally, there is a tendency to recruit assistants under the unskilled or semi-skilled categories and to train them a bit for skilled jobs, without paying them at the rate of skilled workers. Given the low educational background and very superficial `training' by the doctor, most assistants cannot really cope with the responsibilities thrust on them. Hence, the quality of care is poor and the patients suffer. With hardly any knowledge of the basic principles involved in the work they are

doing, the unqualified assistants make mistakes, especially when unforeseen events occur. Due to long hours of work (in many small hospitals, the shift lasts 12 hours), and poor payment, the staff is dissatisfied. This reflects in the poor quality of work. Doctors argue that they cannot afford to employ qualified nurses, or pay the staff better salaries. Doctors are comfortably well-off and this familiar argument cannot be accepted. It is however true that qualified nurses are in short supply. This is partly due to their migration to the Gulf. Secondly, education given in the formal training schools for nurses is quite unsatisfactory today. Fresh graduate nurses have to be taught many things. Hence the preference to employ untrained persons (whose salary expectation is low) and then to train them for the specific job to be entrusted to them. But the quality of such training is low, as there is no training of the basic principle involved. There is a need for proper basic education as well as continuing education of paramedics and some incentive in the form of a share in the prosperity of the hospital, in order to make this category of hospital functionaries better workers.

3.11. Patients' Perceptions

Even a preliminary analysis of just 60 responses of a survey to find out the perceptions of patients about the quality and price of medical care is quite revealing. More than half the respondents felt that the waiting period to see the doctor was too much; that doctors give only partial information about the diagnosis and the side-effects of drugs, that standardization of doctor's fees is quite necessary; that no receipt of payment was given unless it was specifically asked for. About 40% of the respondents felt that the doctors' fees were unreasonable and 30% were not at all satisfied with the treatment given.(71)

These responses are from a self-selected population sample which was motivated to respond probably because many of them were hurt by the medical care system in one way or the other. In spite of the biased nature of this sample, these responses do indicate a trend in patients' perceptions of private medical services.

To summarize then, the brief survey of the problems in private practice from the point of view of rational, ethical practice shows that these problems are largely due to the unregulated operation of the 'law of the market' in which the consumer (the patient) is, for peculiar reasons, in a distinctly

disadvantageous position. Secondly, medical practice has become more of a business than a profession, thanks to the overall commercialization of our society. Unless there is some radical change in the functioning of the private sector in health, neither will the people get a fair deal, nor the doctors professional, moral satisfaction, or the paramedic staff justice and a worthwhile role in the health care system.

Let us, therefore, now turn to the issue of possible solutions to overcome the problems we have discussed.

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4. THE REFORMS NEEDED

4.1. Possible Macro Solutions

As in India today, the health care system in the West was mostly in the private sector till the 1940s. Thereafter, in the U.K. the National Health System was formed, which was mostly a nationalized system with some option for doctors to opt partly or fully for private practice. In other developed capitalist countries, including Japan (but barring the U.S.) there has been some form of National Health Insurance in which the local and/or Central government pays the doctor for those cases which she/he treats. In case of hospitalised treatment, the hospital is paid by the State.

It is thus a publicly financed but privately managed health care system. Even in the U.S. the majority of the population is covered under some form of private medical insurance. Thus, the patients do not have to pay directly to the doctor or the hospital even though the clinics and hospitals are privately owned. In the U.S. there are a number of insurance companies competing with each other and the administrative expenses of such a multitude of insurance agencies is much more than that of a universal, national medical insurance in a comparable country like Canada.(72) The rise of medical insurance, whether private or national, has proved to be the most important step towards regulating the practices of the doctors and hospitals. This is because the payer is now a powerful institution which can successfully bargain with the medical lobby for rationalisation of the fee-structure and medical interventions. Even the content of medical intervention is now being questioned.(73) Rationalisation of fees and medical interventions could not be successfully bargained for by atomised, individual buyers of health-care. In India also, it is difficult to imagine as to how the medical lobby would rationalise its operations unless the buyer of health care has some clout. Many of the reforms suggested below would not be implemented unless there is a strong lobby interested in implementing these reforms. A strong health movement can succeed in creating public opinion in favour of reforms. But to carry through the reforms in practice would require continuous, comprehensive vigilance on a long term basis. Movements are, by their very nature episodic and cannot be expected to do this work on a sustained basis. The individual

patient, as pointed out in section 3.1, is rather helpless before the doctor. Therefore, though some of the reforms suggested below can be implemented without a universal, national medical insurance, the package has been presented in the context of such a national medical insurance.

The second option before us is nationalisation of health services as has been done in the U.K. (We are not considering here the option chosen by countries like Cuba and China, because their overall system is quite different from the capitalist system we have adopted). However, with the current trend towards privatisation of existing public utilities, this option is today politically far more difficult to argue for. Secondly, it is true that in India, public vigilance over public institutions on a day-to-day basis if far more weak compared to that in developed, capitalist societies. A nationalized sector, therefore, tends to become bureaucratic far more easily in our country. Bureaucratic apathy is very much inimical to a highly personalised, delicate service such as medical-care. Therefore, a publicly funded, yet privately managed medical-care system seems to be a better option today, in India. Such a system, would not however, be concerned with preventive and health educational measures at a social level. The existing Public Health Service Sector can be used for this work. It is already doing this work, the question is to improve and extend its functioning. The third option is the American path. In a way we are following it. There has been arise in the corporate sector-medical insurance nexus. But this type of medical care is simply unacceptable. It is too costly for India, apart from being undesirable for any country. One important element of the predominantly private health care system in the U.S. is the rise of malpractice/negligence claims against doctors. In India also, there has been a rapid rise of such legal cases against doctors. Malpractice suits are a necessary weapon in the hands of the patient to get some justice for the harm done to them. But in the absence of a thoroughgoing reform to eliminate the cause of malpractice, these legal battles are counter-productive. Doctors in the U.S. are paying billions of dollars every year to patients for malpractice/negligence. Every American doctor insures himself /herself against professional liability. The professional liability premium of doctors have increased by about 2.5 times in a matter of just 10 years, in the seventies. All this expense is ultimately recovered by doctors from the patients. In litigations, a substantial part of the insurance money is spent on the lawyer and the administration.

For example,in the U.S., insured patients receive, on an average, 30 cents of every premium dollar paid by physicians for professional liability insurance.(74)

Secondly, the fear of law-suits has not improved the quality of medical care (75) but has increased the cost of medical care due to a defensive, over-cautious approach leading to unnecessary investigations. John R. Ball, the then Executive Vice President of the American College of Physicians, pointed out the impact of these legal battles as "...I do see a negative impact, primarily because we begin to do more (medical procedures) that have not been shown to be worthwhile".(76) Thirdly, with the creed of malpractice litigations, doctors and patients look upon each other as potential enemies. This lack of trust is quite damaging to medical care as such. The American option has therefore to be rejected.

Let us now turn to the concrete reforms needed to regulate the private health sector in India.

4.2. Medical Colleges

Private medical colleges should be closed down. No compensation whatsoever should be paid to them.

Medical education should be made relevant to Indian conditions, to the practice of a basic doctor and to the practice of a general practitioner. Primary Health Care providers and G.Ps should be on the teaching faculty of the medical college and a substantial part of training should occur outside the hospital-setting.

4.3. Licentiate Medical Practitioners

The system of registering medical practitioners on the basis of experience alone should be discontinued. Existing RMPs must undergo adequate training for delivering Primary Health Care on a scientific footing. These Primary Health Care providers should be allowed to deal with only a specified type of conditions with the help of limited number of drugs.

A new category of Licentiate Medical Practitioners should be trained to provide Primary Medical Care, to the rural people with the help of a limited number of drugs. These LMPs would help to

reduce the urban-rural disparity in the provision of at least Primary Health Care. If possible, the system of LMPs should also be encouraged in urban areas. Their fees should be fixed and these should be at a level lower than that of doctors.

Both these categories should compulsorily participate in continuing medical education on the lines similar to the CME for doctors as outlined below. Renewal of the license should be subject to proper participation in CME as in the case of doctors.

4.4. Ban on Cross-Prescription

Prescription of allopathic drugs by non-allopathic practitioners and vice-versa should be banned. This provision is easy to implement. A 'cross-prescription' by any practitioner would be an automatic proof of violation of this provision. Stocking of drugs belonging to other systems of medicine can also be easy to identify.

This provision would not debar anybody from acquiring professional knowledge of more than one system of medicine. The only expectation is, one should undergo some systematic training before practising any system of medicine. There could be even a Licentiate Course in each of these systems of medicine and one practitioner can be a graduate in, say, allopathy and a licentiate in Ayurveda (and vice-versa) and use a limited number of drugs for specified, limited types of conditions while practising the 'other' pathy.

The Supreme court, through a recent landmark judgement, has specifically called illegal, the use of allopathic medicine by non-allopaths. In delivering its judgement on 22nd April-92, on an appeal by Dr. A.K. Subhapathy, the Supreme court struck down the legality of the power of the State Government to permit persons not qualified in modern medicine to practice allopathy. (77)

The various state governments can and should implement this Supreme-court-order to stamp out cross-practice. But this has not happened because of apathy of the governments and the lobby of non-allopathic doctors. Because of such lobbying, the Maharashtra Government has, through an order, allowed Ayurvedic Practitioners to practice allopathy "to the extent of the training they received in that system" (78) The Indian Medical Association in Maharashtra has challenged this order in the

Bombay High court. The Supreme court judgement offers an excellent opportunity to stamp out cross-practice. It will be a great pity if this opportunity is wasted. Non-allopaths should receive some systematic training in allopathic therapeutics and then allowed to use a limited number of allopathic drugs.

4.5. National Medical Education Board

Such a Board should be formed to make medical education more relevant and to conduct continuing medical education. The Board should publish a journal each, for Licentiate Medical Practitioners, for General Practitioners and for each of the main specialities like paediatrics, surgery, etc. Such journals should be published in collaboration with IMA and with respective associations of different specialities. One of these journals must be sent to each medical practitioner, depending upon the type of practice of the practitioner. The subscription to the journal should be collected at the time of renewal of registration, say, every three years. A proof of participation in CME of 150 hours every three years is now required in some of the states in the U.S. for renewal of registration.(79) In India modified system would be more suitable. A periodic test consisting of objective questions to be answered by consulting these journals and books should be conducted. The answer-sheet would be sent back by post for evaluation. This test would be conducted to ensure that the journal for CME is read seriously by the practitioner. Re-registration should depend upon satisfactory performance in such a test. Practitioners should give such a test again in case of failure.

4.6. Elimination of Influence of the Drug Industry

It is well-known that the drug industry has an unhealthy influence on the prescription practices of doctors. This influence must be eliminated. Distribution of drug samples to doctors has no role whatsoever in rational therapeutics. Hence it should be banned. Gifts of any kind should also be banned. This seemingly stringent provision is necessary because drugs form a unique product in the sense that the patient who pays for them has no choice but to follow the doctor's prescription. Hence the possibility of any non-therapeutic consideration influencing the doctor's prescription has to be eliminated.

Sponsoring of a trip to any conference or other such programmes has to be, of course, banned. As a matter of social responsibility, drug companies should contribute to the general fund for CME programmes of IMA and other such organisations. This contribution should not be in the form of lunches, dinners, gifts, etc.

Secondly, they should have no role in the content of the programme. Their contribution can be acknowledged but no special advertisement be allowed. Similar provisions should apply to eliminate unhealthy influence of the equipment manufacturers and the corporate medical centres.

The government should statutorily contribute funds to CME programmes.

In the USA, the drug information supplied to doctors needs prior approval of a vigilant body like the F.D.A. A similar provision should apply to the Indian drug industry.

A number of provisions are required to improve the abysmally unhealthy practices of the drug industry in India. These have been put forward by the All India Drug Action Network.(80) These comprehensive suggestions need a separate discussion. Here we would point out to only one provision which directly affects medical practitioners' functioning - the need to prepare a prioritised list of rational drugs, to prioritise production of drugs according to this list and the need to ban all other drugs, as well as to disallow brand names.

4.7. Regulation of Nursing Homes

There should be an All India Nursing Home Act, on the lines of the Bombay Nursing Home Act, 1949, but more specific than the latter.

This act should specify the space, ventilation, sanitation, medical equipment and personnel for various categories of hospitals. The category of the hospital, types of cases that can be safely treated in that hospital, and the minimum facilities expected in that hospital should be clearly displayed in each of the hospitals so that patients themselves and their relatives can question any laxity in the quality of medical facilities in any hospital.

4.8. Standard Treatment Guidelines

There is a tremendous variation amongst doctors in the mode of management of the same ailment. In India, this variation is hardly ever part of any research but is often due to the ignorance of doctors about the current scientific status of different treatment schedules. Many a time treatment schedules reflect sheer personal idiosyncracy and an irrational `faith' in a particular mode of management. Therefore, there should be standard treatment guidelines for various conditions and doctors should be answerable to a Medical Audit Committee for any substantial variation from these guidelines. There should be professional auto regulation of standards and ethics of medical practice. Over and above this, the Medical Council can intervene. Medical Councils should be more active. According to Sec. 62 (1) and 71 (2) of the Maharashtra M.C. Rules, 1967, the Council can conduct inquiries in the absence of any complainant.

The standard treatment guidelines may consist of more than one mode of management, if necessary, because in medicine there are different schools of thought and so long as they have some scientific rationale (which may even be social) aiming to serve the patient better, different modes of management for the same ailment would continue. However, in the West, there is an increasing awareness of the need to critically reassess different conventional and new medical technological interventions.(81) The results of such reassessments.(82) should be widely publicised in India and the unequivocal results should be integrated into standard treatment guidelines. These results must, of course, be assessed in the context of the Indian situation and modified accordingly. Guidelines should also be prepared for the necessary investigations that should be carried out for at least major diseases.

The concept of Standard Treatment Guidelines and Medical Audit has taken roots in the West. It is not an infringement on the clinician's judgement but is an attempt to protect the interests of the patients from unscientific practices. These guidelines can be prepared and enforced if there is a powerful payer of medical bills, like the government.

As argued earlier in section - 3.5, the Consumer Protection Act 1986, is a good opportunity for socially conscious doctors to lobby within their own medical associations, like I.M.A. to institute standard guidelines.

4.9. Mandatory Record Keeping

If there has to be any rationalisation of medical practice and any medical audit, proper clinical records are a must. Important clinical findings, probable diagnosis and treatment must be recorded on the case paper. As a matter of the patient's right, a photocopy of this clinical record must be made available to the patient, if demanded. Photocopying charges will of course be borne by the patient.

4.10. Rationalisation of Doctor's Fees

Doctor's charges should be based on the doctor's qualification, area of practice (urban, rural, metropolitan) and in case of procedures and surgeries, the nature of procedure. Reputed and experienced doctors would draw more patients and hence earn more. These attributes should not, therefore, be given much weightage in deciding the basic rates. In case of general practitioners, examination charges should be separately levied from 'treatment - charges'. This would decrease unnecessary injections. When drugs are dispensed by doctors there would be proper labelling, as per the law, and the charges for medicines should not be more than the cost the doctor has incurred, including the overheads.

Many employers have fixed the upper limit of the reimbursable amount for different aspects of hospitalisation including different types of investigations and surgeries. Similarly, some trust hospitals have also set an upper limit to the charges tolevied for different services, procedures, surgeries. The actual amount could be debated. But this system is irrespective of who does the surgery and is more just and egalitarian than the current system of arbitrary and exorbitant charges by some surgeons.

All these charges should be revised every year by automatically linking them with the consumer price index. The whole package should be reviewed every three years.

4.11. Participation in National Health Programme

Practitioners must participate in National Health Programmes for major diseases like tuberculosis, malaria, leprosy, etc., and cooperate with the government by notifying the notifiable diseases, including some occupational diseases and injuries.

Practitioners should also participate in health educational activities. The public health authorities and the associations of doctors should together prepare posters, slides, pamphlets, for health education about a variety of common diseases as well as medical procedures (for example, on what is an x-ray and what is its use, adoption of children, etc.), and this should be widely circulated through practitioners. Proper health education is quite essential for good medical practice.

4.12. Justice to Paramedic Staff

The minimum wages of the practitioner's assistants, should be linked to the Consumer Price Index and should be revised every five years to take into account the changes in the socio-economic situation.Paramedics must have promotional avenues, encouragement for upgrading their training through periodic, systematic, continuing medical education. Medical care is team work and paramedics should get a share in the prosperity of the clinic or hospital. Promotion and share in increased income should, however, be subject to performance and there should not be any complacency about work ethics in serving the sick.

4.13. Implications of Reforms

The reforms suggested above imply far-reaching changes in our medical care system. A section of doctors who earn far more than the quantity and quality of their work would steadfastly oppose these reforms and other doctors may be misled by them. But in a regulated system, an average, honest doctor would be more happy. The increasing commercial and unethical competition is making it more and more difficult to do rational, ethical practice.

Universal medical insurance would reduce the incentive to do unethical practice. Secondly, the people who do not seek medical care today due to poverty, would do so due to universal insurance and this would mean a substantial increase in work for doctors. Since commercial pressures will cease to be the over-riding concern, doctors will get back the professional satisfaction of proper diagnosis, proper advice, and relief of suffering of the patient. In the absence of universal insurance, however, a large section of doctors would oppose measures to regulate their practice and a lot of public pressure will have to be built up for each of the reforms suggested above.

Universal medical insurance would mean that the government will have to spend a lot more on medical care. But in any case, the current governmental expenses on health care are too meagre - a mere 1.17% of GNP, as compared to 5% of the GNP recommended by the WHO, for the achievement of the declared goals of Health For All by 2000 A.D.(83) Yet, the latest strategy of the government is to reduce state expenses on social services. There will have to be quite a bit of pressure from the public to reverse this trend. The government may levy an additional health care tax on the well-to-do to partly cover the increased budget for health care. It should, however, be much less than what the people are spending today on private health care. Otherwise, the people would not benefit from the new scheme.

On the whole, universal medical insurance should be operated in a decentralized way, as part of the proposed Panchayati-Raj. But, since the Central Government collects most of the taxes, the decentralized set up must get statutory, regular and adequate share from the central funds. Otherwise, backward regions will have less funds and regional disparities would not lessen.

Regulation of the private sector would thus mean far-reaching policy changes. Pressure of enlightened public opinion is quite essential to initiate any of these changes. A wide ranging public debate is needed towards that end.

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5. RECOMMENDED AREAS FOR RESEARCH

As pointed out at the beginning of this chapter, there is very little systematic research on the private health sector in India. The following areas can be pointed out for research.

5.1. Medical Education

5.1.1. Precise area and mode of improvement in medical education from the point of view of clinic-based practice and small hospitals.

5.1.2. Quality of training in private non-allopathic medical colleges and their functioning in general.

5.2. General Practitioners and Consultants

5.2.1. Number, distribution, functioning of unqualified medical practitioners. Quality of care rendered by them. What is their reaction towards the proposal for retraining, CME, regularisation and regulation?

5.2.2. Documenting the functioning of non-allopathic medical practitioners.
To what extent do they practice allopathy? What are their sources of training in allopathy?

5.2.3. Comparative study of the quality of prescription by non-allopathic graduates, allopathic graduates and post-graduates. How frequently are injectables given? Their rationality? Rationality of the current practice of advising investigations in different diseases.

5.2.4. Income of different types of practitioners in different representative areas; their economics in general, including compliance with Minimum Wages Act.

5.2.5. CME activities amongst practitioners - the level of participation; what percentage of practitioners read scientific literature, to what extent?

5.2.6. KAP studies of doctors about different major diseases. KAP of their paramedics.

5.2.7. Work-load of practitioners; time spent for or each patient; can they do justice to the patients? Quality of records kept. Nature of GP's set-up, preparedness for emergency care, level of cleanliness, sterilization.

5.2.8. Patient's experiences and perceptions of doctor's attitude, behaviour, medical treatment, charges levied.

5.2.9. Doctor's perceptions about different aspects of practice.

5.3. Hospitals, Laboratories

5.3.1. Urban-rural disparity of different types of hospitals.

5.3.2. Quality of laboratory and other investigations; factors affecting quality; quality of training of laboratory workers, their KAP about their work. Relations behind charges levied to the patients.

5.3.3. Nature and quality of set-up of private hospitals, including space, ventilation, light, sanitation, cleanliness, medical equipment and personnel; economics of setting up and running of hospitals of different sizes in different representative areas.

5.3.4. Evaluation of record keeping, rationality of treatment given; variation amongst hospitals and comparison with established specifications. Rationality of hospital charges, consultants' and surgeons' fees, amount of variation.

5.3.5. Difference between trust hospitals, corporate hospitals and small private hospitals as regards different aspects - facilities, quality and rationality of care, charges, concessions to poor patients, quality of staff,their salaries, functioning, etc.

5.3.6. Patient's and doctor's experience and perceptions about the functioning of hospitals.

5.4. General Issues

5.4.1. Role of private sector in health education, National Programmes, preventive measures.

5.4.2. Number and trend of malpractice/negligence suits their outcomes, attitude of medical associations and fellow doctors in such cases.

5.4.3. Opinion of different strata of people, of doctors, hospital staff, as well as those of policy-makers and opinion-makers, about regulation of and reforms in the private sector.

5.4.4. Amount of wastage due to unnecessary, irrational drugs, unnecessary injections, investigations, procedures, surgeries.

In short, almost all the issues discussed in this chapter need systematic documentation and research so that the need for reforms in the private health sector would emerge on a much firmer basis and the mode of reforms, their implications can be worked out in a better, clearer way.

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THE PRIVATE MEDICAL SECTOR IN INDIA

In this critical review of the functioning of the private sector in medical care in India, Dr. Anant Phadke has identified a number of features of the private sector which are an obstacle to the development of a rational, affordable, socially just medical care system in India. The author first describes these defects such as costly yet sub-standard private medical colleges, which are unnecessary in the first place; lack of Continuing Medical Education of doctors; irrational drug-use; widespread "cross-prescription practices"; unnecessary medical interventions; lack of regulation and standardization of quality of nursing homes and of medical interventions; lack of preventive measures and health-education; sub-standard, poorly paid staff, etc..... To remedy this situation, the author has suggested a number of wide-ranging reforms, which, according to him, can be carried out effectively within the framework of Universal Medical Insurance, as has been done in countries like Canada and Australia. The reforms suggested by the author are :-

* ban on private medical colleges;
* compulsory continuing education of doctors;
* ban on irrational and hazardous drugs;
* ban on cross-prescriptions;
* standardization of medical interventions, of nursing homes and of professional charges;
* mandatory minimum medical record keeping;
* participation of private practitioners in National Health Programmes;
* proper training of paramedical staff and giving them a proper share in the prosperity of the clinic/hospital;
* tightening of professional self-regulation by doctors' associations.

The author answers that the inclusion of doctors in the Consumer Protection Act 1986, would not help to improve the quality of medical care to patients if no progress is made in the direction of the reforms suggested above.

Though the private sector in India occupies a dominant share and position in the medical services, there are hardly any studies which have analysed its functioning. In the context of the increasing trend towards further privatization of medical services in India, this critical study of the private sector in health care stands out boldly. It should interest anybody concerned with the fate of the medical services in India.